Anniversary Celebration
仁安醫院三十周年

UNION Connection

VOL 218 | November 2025

Message from the Chief Hospital Manager

Dear Colleagues,

In the first week of October, I took a week off and visited my relatives and friends in Toronto Canada. The weather was wonderful with clear blue sky and gentle breezes every now and then. My sisters told me that we were lucky because if it rained, going out would be quite unpleasant. My relatives in Toronto had emigrated there quite some years ago and some of them were civil servants from Hong Kong who opted for early retirement before immigration. Thus they have been living comfortably on the financial return of their investments and their pensions from HKSAR's tax-payers money, i.e., yours and mine included!

During the six days sojourn in Toronto, I had the pleasure to sample more than ten Asian style restaurants mainly located in the township of Markham. With the exception of a Japanese restaurant which could serve delicious toro and hamachi sashimi, the others were supposed to specialize in Cantonese cuisine. These latter ranged from the Cha Chaan Tang like 'Congee Queen' to the rather luxurious 'Lobster Port'. One common feature of these restaurants was their huge seating capacity compared to those in Hong Kong. What amazed me was that they were quite fully occupied, be it lunch or dinner, when my friends or relatives took me and my wife out. My reasonable conclusion was that most Chinese residents in Toronto have good spending power! Moreover the three most costly food ingredients are lobsters, Alaskan King crab, and Geoduck and they are usually featured in reasonably prized set dinners for 6 or 12 guests. The price for these set dinners ranged from CAD 60 to CAD 80 person and these should be very affordable and reasonable. Thus I must admit that the cost of living in Hong Kong is much much higher and it is no wonder that Canada is one popular choice for people emigrating from this part of the world.

As far as Western countries are concerned, the healthcare system in Canada probably ranks number one as far as equity is concerned. Everybody is equal when it comes to seeking medical treatment. One has to follow the queue if one needs a consultation with a specialist. Very commonly, the appointment often carries a waiting period longer than a year. When I was in active practice in Hong Kong twenty plus years ago, I often saw Hong Kong emigrants in Canada travelling back to HK to seek a rheumatologist's opinion! Moreover, doctors in Canada have no incentive to see more patients because they are being paid by the government at fixed rates and the income tax rate is very high once the modest threshold for the top tier is reached. Hence I can only conclude that the healthcare system is equitable but poorly accessible.

Fortunately for Chinese residents in Toronto, there is a well-managed voluntary charitable organization – Carefirst Seniors and Community Services Association whose mission and vision are to provide integrated health and social care to the ageing community. Its current CEO (Chief Executive Officer) Ms Helen Leung happens to be a cousin of mine from my mother's side of the family. Hence I have first hand information of the good work they have been doing during my recent visit. 'Carefirst' has been offering a comprehensive multi-disciplinary program for the underprivileged singles or families in the local community which includes assisted living services, homecare services, primary and specialist clinical care services, etc. The various services rendered by the organization have been highly regarded by the local community and the regional government officials.

There is one moot point in the Canadian government provided healthcare services for the elderly. It seems that costly procedures like haemodialysis for chronic kidney failure will not be financed once the patient reached the age of eighty! It seems a bit cruel to the family members of the patient and is like a slow-process of fatal execution. This is a genuine happening to the elder brother of a classmate of mine which intrigued me because Canada is supposed to be a country renowned as a welfare state!

Goodbye for now and wishing you a nice Autumn leading to the Holiday season!

Yours most sincerely,

Dr Anthony K Y Lee
Chief Hospital Manager & Medical Director

Magnetic Resonance Imaging of Ankle Ligaments Anatomy and Injury Patterns

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Union Hospital

Introduction

The ankle, a critical weight-bearing hinge joint, depends on a complex ligamentous network for stability during movement. Injuries from inversion (85%), eversion (5-10%), or rotational forces (10-15%) affect the lateral, deltoid, or syndesmotic ligaments, with 20-40% of cases progressing to chronic ankle instability (CAI). This article explores the MRI-based anatomy of ankle ligaments, focusing on their normal appearance, injury-specific findings, and diagnostic implications.

MRI protocols

Standard ankle MRI protocols utilize T1-weighted, T2-weighted, and proton density (PD) sequences with fat suppression, acquired in sagittal, coronal, and axial planes. Short tau inversion recovery (STIR) sequences enhance detection of oedema and fluid, crucial for identifying acute injuries. Advanced 3D isotropic imaging enables multiplanar reformatting, improving visualization of complex injuries. A dedicated ankle coil optimizes signal-to-noise ratio for clearer images.

MRI Anatomy and Injury Findings of Ankle Ligaments

Lateral Ligament Complex (Figures 1 and 2)

The lateral complex, resisting inversion, includes three ligaments:

- **Anterior Talofibular Ligament (ATFL):** Originating from the anterior distal fibula and inserting on the talar neck, the ATFL appears on axial/sagittal MRI as a 2-3mm thick, low-signal band. It is the most frequently injured ligament in ankle sprains (70%), with acute tears showing T2/PD hyperintensity, fiber discontinuity (Grade III), or periligamentous edema. Chronic tears present as thickened, irregular low-signal scarring or non-visualization, contributing to CAI.
- **Calcaneofibular Ligament (CFL):** Extends from the fibular tip to the calcaneal peroneal tubercle, seen best on coronal/sagittal views as a 3mm wide, low-signal structure. Injury is often associated with ATFL involvement.
- **Posterior Talofibular Ligament (PTFL):** Anchoring the posterior fibula to the talar tubercles, the PTFL appears as a broad, low-signal band on axial/coronal views. Tears, rare (10%), occur in high-energy trauma, showing posterior talar oedema or fiber discontinuity.

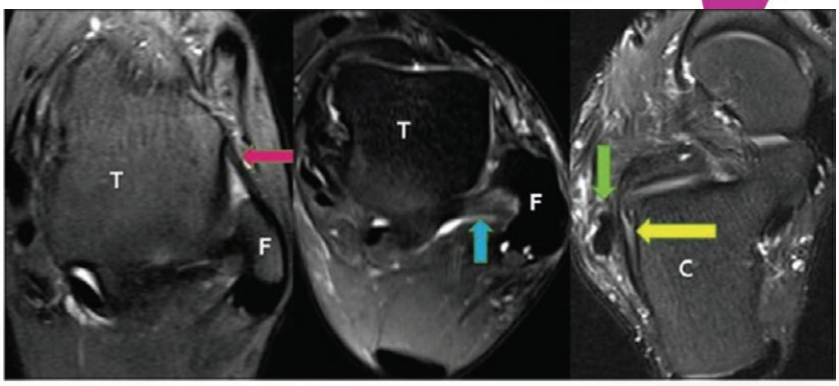

Figure 1: Normal anatomy of the lateral ankle ligaments: MRI of intact anterior talofibular ligament (pink arrow), posterior talofibular ligament (blue arrow) and calcaneofibular ligament (yellow arrow). Keys: T – Talus, F – Fibula, C – Calcaneum (Sawant YN, Sanghvi D. Magnetic resonance imaging of ankle ligaments: A pictorial essay. Indian J Radiol Imaging. 2018 Oct-Dec;28(4):419-426)

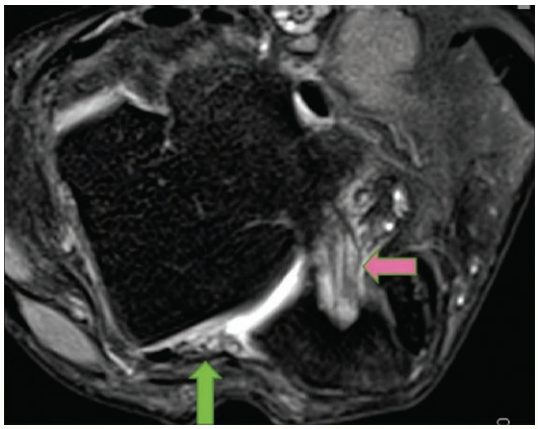

Figure 2: Inversion injury with discontinuous anterior talofibular ligament (green arrow), signifying complete tear. There is also oedema with loss of striations of the posterior talofibular ligament (pink arrow), suggestive of partial tear. (Sawant YN, Sanghvi D. Magnetic resonance imaging of ankle ligaments: A pictorial essay. Indian J Radiol Imaging. 2018 Oct-Dec;28(4):419-426)

Medial Deltoid Ligament Complex (Figures 3 and 4)

The deltoid, countering eversion, has superficial and deep layers. The deep ligaments have talar attachments and cross one joint, whereas the superficial ligaments have variable attachments across two joints. The three components that are most often visualised on MRI include the *tibiospring and tibionavicular ligaments (superficial), and the posterior tibiotalar ligament (deep)*.

- **Tibionavicular ligament (TNL):** Courses from the anterior colliculus to the navicular, crossing the ankle and talonavicular joints. Visible in only 55% of asymptomatic individuals, it is unreliable for injury assessment
- **Tibiospring ligament (TSL):** The strongest superficial ligament and the only deltoid ligament that inserts onto another ligament. It crosses both ankle and anterior subtalar joints and connects the medial malleolar colliculus to the superior border of the superomedial spring ligament.
- **Tibiocalcaneal ligament (TCL)**: Links the anterior colliculus to the sustentaculum tali.
- **Anterior tibiotalar ligament (ATTL):** A thin, variably visible structure, sometimes absent as a normal variant.
- **Posterior tibiotalar ligament (PTTL):** The strongest component of the deltoid ligament. It attaches to the posterior half of the colliculi of the medial malleolus and medial tubercle of the posterior process of the talus. it shows a striated appearance due to intervening fat.

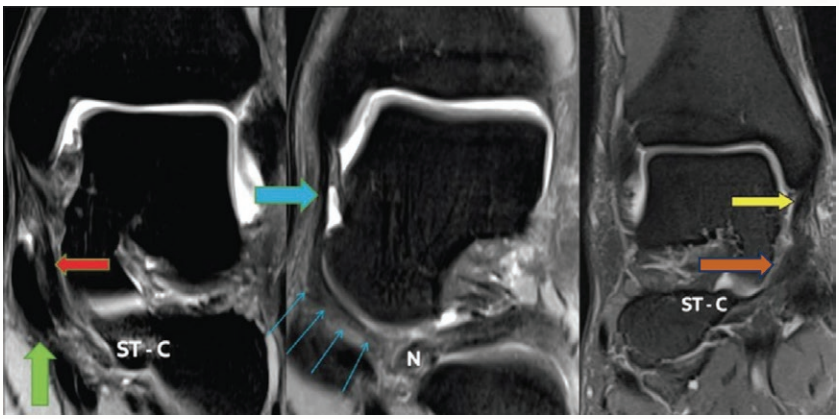

Figure 3: Normal anatomy of superficial deltoid ligaments: MRI of intact tibiocalcaneal ligament (red arrow) which lies below the posterior tibialis tendon (green arrow), tibionavicular ligament (blue arrow), and tibiospring ligament (yellow arrow) which merges with the superomedial component of the spring ligament (brown arrow). Key: N – Navicular, ST-C – Sustentaculum Tali of Calcaneum. (Sawant YN, Sanghvi D. Magnetic resonance imaging of ankle ligaments: A pictorial essay. Indian J Radiol Imaging. 2018 Oct-Dec;28(4):419-426)

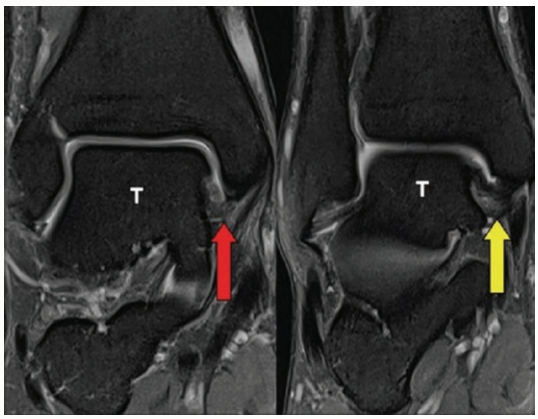

Figure 4: Normal anatomy of deep deltoid ligaments: MRI of thinner intact anterior tibiotalar ligament (red arrow) and thicker intact posterior tibiotalar ligament (yellow arrow). Key: T – Talus (Sawant YN, Sanghvi D. Magnetic resonance imaging of ankle ligaments: A pictorial essay. Indian J Radiol Imaging. 2018 Oct-Dec;28(4):419-426)

Syndesmosis (Figure 5)

The syndesmosis stabilizes the tibiofibular joint:

- **Anterior Inferior Tibiofibular Ligament (AiTFL):** Runs obliquely from the anterior tibia to the fibula, seen on axial/oblique views as a thin, low-signal band.
- **Posterior Inferior Tibiofibular Ligament (PiTFL):** Posterior counterpart, broader, seen on axial/coronal views. Less commonly injured than AiTFL.
- **Interosseous Ligament:** A thick, low-signal band between tibia and fibula on coronal views.
- **Inferior Transverse Ligament:** Reinforces the PiTFL, rarely injured in isolation.

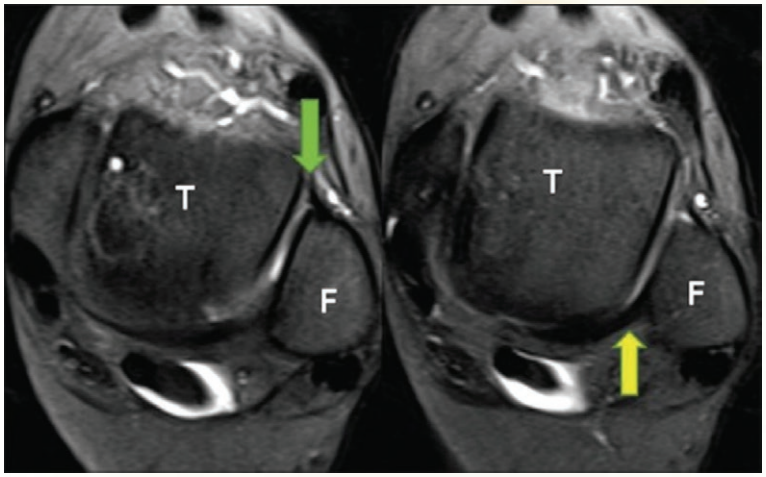

Figure 5: Normal anatomy of syndesmosis ligaments: MRI of anterior (green arrow) and posterior (yellow arrow) inferior tibiofibular ligaments. Key: T – Talus, F – Fibula (Sawant YN, Sanghvi D. Magnetic resonance imaging of ankle ligaments: A pictorial essay. Indian J Radiol Imaging. 2018 Oct-Dec;28(4):419-426)

Spring Calcaneonavicular Ligament Complex

Spring ligament injuries are often associated with posterior tibial tendon dysfunction.

- **Superomedial calcaneonavicular ligament (SM-CNL):** Largest component of the spring ligament complex, and lies deep to the posterior tibialis tendon (PTT). It originates from the sustentaculum tali and inserts on the superomedial aspect of the navicular tuberosity before fusing distally with the TSL of the deltoid. It is the most frequently involved component of the spring ligament in acute traumatic injury.
- **Inferoplantar longitudinal calcaneonavicular ligament (IPL-CNL):** thick ligament from the calcaneal coronoid fossa to the navicular beak, visible in 91% of asymptomatic individuals.
- **Medioplantar oblique calcaneonavicular ligament (MPO-CNL):** Originating anterior to the IPL-CNL, it attaches to the navicular tuberosity, showing fiber striations on axial views.

Associated Pathologies on MRI

MRI identifies comorbidities altering management:

- Osteochondral Lesions: Talar dome defects (50% of severe sprains) appear as subchondral T2 hyperintensity or cysts, with lateral lesions more symptomatic.
- Peroneal Tendon Pathology: Splits or subluxation show tendon discontinuity or peroneal sheath fluid.
- Capsular/Synovial Changes: Hemarthrosis (high T2 intra-articular fluid) or anterolateral synovial hypertrophy signals impingement.

Chronic Sequelae and Impingement

- Chronic Ankle Instability (CAI): ATFL/CFL show thickened, low-signal scarring or absence, without residual soft tissue oedema or haemorrhage.
- Anterolateral Impingement: “Meniscoid” scar tissue in the anterolateral gutter (intermediate T1/T2 signal) with synovial hypertrophy.
- Posteromedial Impingement: Chronically torn, fibrosed PTTL entrapped between the medial talus and medial malleolus.

Conclusion

MRI is essential for evaluating ankle injuries, providing detailed visualization of ligaments, tendons, and cartilage. By clarifying ligamentous integrity and associated pathologies, MRI guides targeted therapeutic strategies, optimizing recovery and preventing chronic instability. As imaging technology advances, MRI’s role in ankle injury management will continue to improve patient outcome.

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Comprehensive Respiratory Services at Union Hospital and Recent Advances in Asthma Diagnosis and Management

Dr Yu Wai Ling
Specialist in Paediatrics
Union Hospital

My name is Dr. Michelle Yu Wai Ling, a specialist in pediatric respiratory medicine. At Union Hospital, we offer comprehensive respiratory services tailored for children, ensuring specialized care for a range of pediatric pulmonary conditions, which aim to deliver accessible, evidence-based, and compassionate pulmonary care to children.

Service Offered:

Sleep Disordered Breathing	Sleep studies for diagnosing and managing of various sleep disordered breathing including Obstructive Sleep Apnea (OSA), Parasomnia, Insomnia and Daytime Sleepiness.
Specialized Asthma management programs	Diagnostic investigations, including spirometry, fractional exhaled nitric oxide (FeNO), and full lung function testing, with individualized action plans incorporating medication management and trigger avoidance strategies.
Allergic rhinitis	Comprehensive allergy testing with with treatment including pharmacotherapy +/- immunotherapy
Chronic Lung Diseases	Personalized care plans for conditions such as bronchiectasis, lung malformations, or bronchopulmonary dysplasia
Thorough evaluations for Chronic Cough	—

Diagnosis of Chronic Cough

Chronic cough in children, defined as a cough lasting more than four weeks, is the most common presenting symptom in pediatric respiratory clinics. It can stem from various underlying causes, often requiring careful evaluation to identify the root issue. The most frequent cause is post-infectious cough. Asthma, another common culprit, is characterized by airway hyperreactivity triggered by allergens, exercise, or weather changes. Other possible diagnoses include allergic rhinitis, gastroesophageal reflux disease (GERD), infections such as tuberculosis, and chronic lung conditions like bronchiectasis, which often present with a persistent productive cough. Less commonly, psychogenic cough due to stress may occur. Accurate diagnosis relies on a detailed history, physical examination, and targeted investigations.

We will discuss asthma, the leading cause of chronic cough in children, providing a detailed overview of its diagnosis and management.

Recent Advances in in enhancing Asthma Diagnosis and Management

Asthma, a chronic inflammatory and reversible obstructive airway disease affecting millions of children worldwide. The 2025 Global Initiative for Asthma (GINA) guidelines highlights three pivotal updates: new criteria for diagnosing asthma in children under five years, the expanded role of FeNO in diagnosis, and refinements in Maintenance and Reliever Therapy (MART). These changes aim to enhance diagnostic accuracy, reduce misdiagnosis in young children, and minimize exacerbation risks, ultimately fostering improved patient outcomes.

Diagnosing Asthma in Children Under Five Years: 2025 GINA Update[1,2]

Asthma diagnosis in preschool children (≤ 5 years) has historically been challenging due to unreliable spirometry, overlapping viral wheeze, and risks of over- or underdiagnosis. The 2025 GINA guidelines introduce a evidence-based framework to enable timely diagnosis and intervention.

The three diagnostic criteria for asthma in children aged 5 years or younger:

Recurrent wheezing	• ≥ 2 acute wheezing episodes in 12 months OR • One acute wheezing episodes plus interval asthma like symptoms
Documented treatment response	• Rapid symptom relief with short-acting β_2-agonist (SABA) OR • Sustained improvement during a 2-3 month trial of low-dose inhaled corticosteroids.
Exclusion of alternative diagnoses	

All three criteria are needed for the diagnosis of asthma in children under 5. For management, confirmed cases initiate daily low-dose inhaled corticosteroids (ICS) (e.g., fluticasone 50 mcg twice daily via spacer), with as-needed short-acting beta2-agonists (SABA) for relief. By enabling earlier ICS initiation, this aims to reduce emergency visits by 20–30% in this vulnerable group, promoting lung health and minimizing long-term sequelae.

Use of Fractional Exhaled Nitric Oxide (FeNO) in Asthma Diagnosis [3-5]

The 2025 GINA guidelines significantly elevate FeNO as a non-invasive, simple, and point-of-care tool for guiding asthma diagnosis and predicting treatment response. Elevated nitric oxide levels indicate eosinophilic airway inflammation, which decrease in response to anti-inflammatory treatment.

FeNO testing is simple, quick (takes 1–2 minutes), and well-tolerated by children as young as 4 years who can exhale consistently.

Elevated FeNO levels (typically >35 ppb in children) support an asthma diagnosis

The test aids in diagnosing eosinophilic or Type 2 airway inflammation, guides treatment decisions, and monitors airway inflammation in patients with asthma.

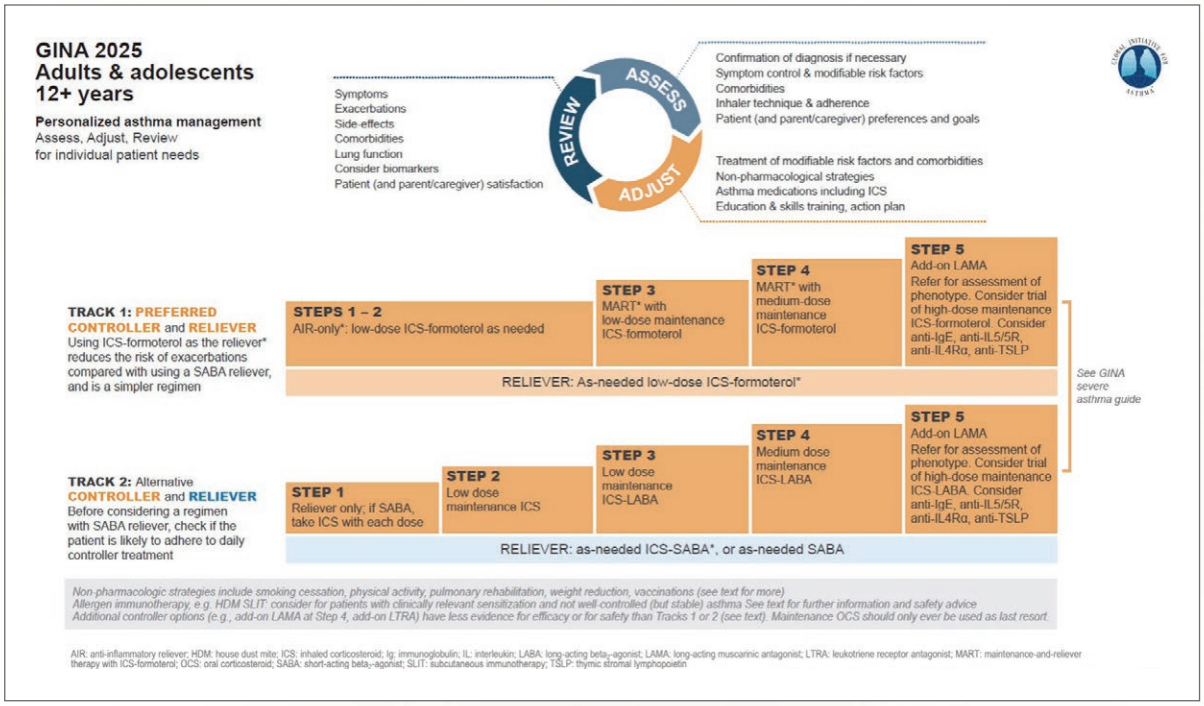
Advancements in Asthma Management in Children and Adolescents:

Maintenance and Reliever Therapy (MART) represents the GINA preferred Track 1 for adolescents and select children, using inhaled corticosteroid (ICS)-formoterol (e.g., budesonide-formoterol) as both controller and reliever. The 2025 GINA guidelines reinforce MART's efficacy at Steps 3–5, reducing severe exacerbations by 20–30% compared to short-acting beta2-agonist (SABA)-based regimens, according to meta-analyses. As-needed ICS-formoterol is now standard for Step 1–2 mild asthma, eliminating SABA monotherapy due to risks of overuse. ICS-formoterol is the only ICS-long-acting beta2-agonist (LABA) suitable as an anti-inflammatory reliever due to its rapid onset of action. Examples of ICS-formoterol include Symbicort and Vannair.

For children aged 6–11 years, low-dose MART is conditionally endorsed at Step 3, balancing efficacy with growth concerns. MART's simplified therapy enhances adherence, with real-world data showing 15% fewer oral corticosteroid courses. De-escalation is recommended after 3–6 months of stability.

A Stepwise Approach from the 2025 GINA Guidelines with MART Therapy

Step 1 and Step 2 (Mild Intermittent Asthma)	As-needed low-dose ICS-formoterol for Track 1 OR as-needed low-dose ICS with separate SABA as Track 2
Step 3: Moderate Asthma	Medium-dose ICS-formoterol MART (Track 1) or low-dose ICS-LABA plus SABA (Track 2).
Step 4: Severe Asthma	Medium-high dose ICS-formoterol MART (Track 1) or medium-dose ICS-LABA with add-on LAMA (Track 2)
Step 5: Difficult-to-Treat/ Severe Refractory Asthma	High-dose ICS-LABA/MART plus add-ons (LAMA, azithromycin, low-dose OCS) Consider Biologics



Conclusion

The 2025 GINA guidelines usher in a biomarker-driven, age-tailored era in asthma care, with fractional exhaled nitric oxide (FeNO) enhancing diagnostic precision, pragmatic criteria simplifying preschool diagnosis, and Maintenance and Reliever Therapy (MART) optimizing treatment. These revisions aim to improve long-term outcomes, minimize overtreatment, and promote remission through personalized, family-centered care.

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TRENDS OF CULTURED PATHOGENS

The Most Frequently Isolated Pathogens from Urine Cultures during May to August 2025

Most Common Pathogens Isolated	***Escherichia coli***	
Period	**May to Aug 2025**	**Jan to Apr 2025**
Number of Isolates per Admission (Total number of Urine Cultures)	**264 (2228) Including 53 ESBL & 1 CPE**	241 (2031) Including 52 ESBL & 3 CPE
Isolation Rate	11.8%	11.8%
Antibiotics	**Non-susceptible Rate**	
Amoxicillin/Clavulanic Acid	28%↑	27%
Ampicillin	74%↑	71%
Ampicillin/Sulbactam	62%↑	59%
Cefazolin (Oral)	27%↓	29%
Ceftriaxone/Cephalosporins 3G	21%↓	23%
Cefuroxime (Oral)	34%↑	32%
Cefuroxime (Parenteral)	27%	27%
Ciprofloxacin*	47%↓	49%
Ertapenem	0.8%↓	1.2%
Gentamicin	15%↓	19%
Imipenem	0.8%↓	1.2%
Levofloxacin*	62%	62%
Nitrofurantoin	4%↓	5%
Trimethoprim/Sulfamethoxazole	34%↓	37%

* Non-susceptible Rate of Levofloxacin & Ciprofloxacin is increased as the criteria for the interpretation of Susceptibility on Levofloxacin & Ciprofloxacin were changed on 1st April 2020.

CPE = Carbapenemase Producing Enterobacteraceae – E.coli

The Most Frequently Isolated Pathogens from Respiratory Secretion Cultures during May to August 2025

Period	**May to Aug 2025**		Jan to Apr 2025	
No of Request	**693**		957	
Pathogens	**Number of Isolates**	**Isolation Rate**	**Number of Isolates**	**Isolation Rate**
Pseudomonas aeruginosa	**48**	6.9%↓	33	3.4%
Staphylococcus aureus (include 10 MRSA)	**48**	6.9%↑	37	3.9%
H. Influenzae	**43**	6.2%↓	61	6.4%
Streptococcus pyogenes (GAS)	**28**	4.0%↓	60	6.3%

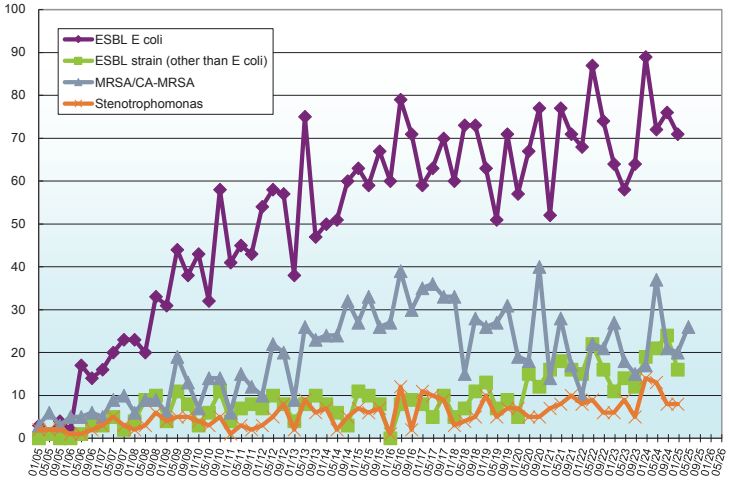
Most common pathogen isolated	Antibiotics	Non-susceptible rate	Most common pathogen isolated	Antibiotics	Non-susceptible rate
Pseudomonas aeruginosa	Cefepime	4%	Staphylococcus aureus (include 10 MRSA)	Erythromycin	14%
	Ceftazidime	6%		Levofloxacin	17%
	Ciprofloxacin	19%		Oxacillin	29%
	Levofloxacin	33%		Penicillin	89%
	Meropenem	13%		Tetracycline	23%
	Piperacillin	0%		Trimethoprim/ Sulfamethoxazole	11%
	Piperacillin/ Tazobactam	10%		Vancomycin	0%

The Most Frequently Isolated Pathogens From Genital Cultures During May to August 2025

Most Common Pathogens Isolated	*Group B Streptococci*		*Candida albicans*		*Yeast (Candida albicans excluded)*	
Period	**May to Aug 2025**	Jan to Apr 2025	**May to Aug 2025**	Jan to Apr 2025	**May to Aug 2025**	Jan to Apr 2025
Number of Isolates per Admission (Total number of Genital Cultures)	**168 (962)**	161 (801)	**148 (962)**	125 (801)	**38 (962)**	27 (801)
Isolation Rate	**17.5%↓**	20.0%	**15.3%↓**	15.6%	**4.0%↑**	3.4%
Antibiotics	**Non-susceptible Rate**					
Cefotaxime	**0.0%**	0.0%				
Clindamycin	**61.9%↑**	59.1%				
Levofloxacin	**16.7%↑**	13.2%				
Penicillin	**0.0%**	0.0%				
Vancomycin	**0.0%**	0.0%				

[1] Suspectible to penicillin can be considered susceptible to ampicillin, amoxicillin, amoxicillin/clavulanic acid, ampicillin/sulbactam, cefaclor, cefazolin, cefdinir, cefepime, cefprozil, cefotaxime, ceftriaxone, cefuroxime, cefpodoxime, ceftizoxime, cephalothin, cephapirin, imipenem, loracarbef, and meropenem.

Trend of ESBL, MRSA & Stenotrophomonasisolated from all specimentypes by quarter since 2005



	ESBL *E coli*	ESBL strain (other than *E coli*)	MRSA/ CA-MRSA	*Stenotrophomonas*
May-Aug 19	51	7	27	5
Sep-Dec 19	71	9	31	7
Jan-Apr 20	57	5	19	7
May-Aug 20	67	15	18	5
Sep-Dec 20	77	12	40	5
Jan-Apr 21	52	16	14	7
May-Aug 21	77	18	28	8
Sep-Dec 21	71	16	17	10
Jan-Apr 22	68	15	10	8
May-Aug 22	87	22	22	9
Sep-Dec 22	74	16	21	6
Jan-Apr 23	64	11	27	6
May-Aug 23	58	14	18	9
Sep-Dec 23	64	12	15	5
Jan-Apr 24	89	19	17	14
May-Aug 24	72	21	37	13
Sep-Dec 24	76	24	21	8
Jan-Apr 25	71	16	20	8
May-Aug 25	82	20	26	3

UNION HOSPITAL 30th ANNIVERSARY CELEBRATION

Anniversary Celebration
仁安醫院三十周年

Welcoming Our 100,000th 'Union Baby'. Three Decades of Care: Witnessing 100,000 Union Baby Stories.

We are excited to welcome the 100,000th Union Baby on 20 September! This milestone celebrates three decades of dedicated clinical excellence in maternal and newborn care. For 30 years, we have been joyous to stand beside more than 100,000 families, witnessing every heartbeat and precious first embrace. It reflects the trust families place in us and our founding mission to be a 'Happy Hospital'.

To congratulate the 100,000th family and other babies born on the same day, we gave each family a commemorative birthday gift with our warmest wishes, creating a joyful atmosphere across the Obstetrics and Gynaecology floor.

Read about the 100,000th Union Baby Story

Cheers to Our Doctors and Healthcare Professionals

This achievement belongs to every doctor and healthcare professional who has walked with Union Hospital. Your clinical expertise, teamwork and compassion over the past three decades have built the foundation for more than 100,000 safe deliveries. Thank you for your unwavering commitment in creating this unbelievable achievement.

Where 100,000 Lives Begin

Union Hospital has been deeply grateful for upwards of 100,000 families making us their choice. The 'Union Baby Stories' are precious treasures, woven from the 'Family Moments' of nurturing a new life, and the 'Voices from Healthcare Professionals' who safeguard each birth. Come join the celebration and share your own 'Voice of Care' to this mosaic of memories.

Explore the '100,000 Union Babies Milestone' website and watch our heartwarming video 'Where 100,000 Lives Begin' which guides you through the journeys of different generations of Union Babies.

Explore our milestone website

Share your thoughts

NEWS & EVENTS

Post-Event Highlights

UH X Kowloon City DHC Express: Orthopaedics Health Talk (17 September 2025)

Co-organised with Kowloon City District Health Centre Express, we delivered an engaging orthopaedics health talk to 30 seniors. Dr Lam Kin Wai, Specialist in Orthopaedics & Traumatology, explained the causes and symptoms of knee degeneration and outlined the latest treatment options. Participants also learned about osteoporosis risk and practical strategies to maintain bone health and reduce the risk of future injuries.

CME Programme – Common Haematological Conditions and Haematological Emergencies in Hospitals (10 October 2025)

We recently hosted an insightful CME lecture titled 'Common Haematological Conditions and Haematological Emergencies in Hospitals' featuring Prof. Anskar Leung, who shared his valuable experience and insights into the daily encounters of a clinical haematologist. He delivered a comprehensive and engaging overview of the CME topic, enriched with pertinent case studies.

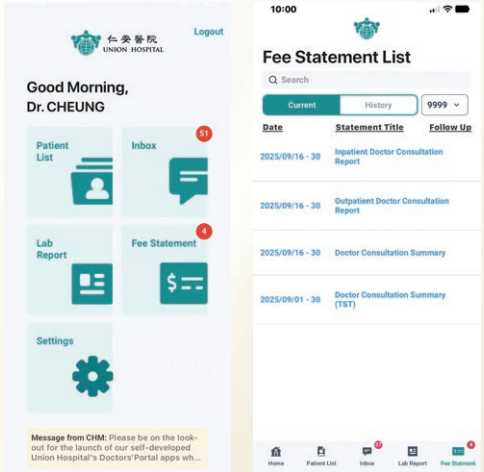
The session was expertly chaired by Prof. Henry Chan, Deputy Chief Hospital Manager at Union Hospital, who facilitated a productive dialogue among attendees. The lecture attracted over 100 participants, both onsite and online, underscoring its relevance and importance within the medical community.

Award Recognition

Sing Tao News Corporation X The Hong Kong Polytechnic University Outstanding ESG Enterprises Recognition Scheme 2025 (21 October 2025)

We are proud to receive three ESG awards: Outstanding ESG Social Performance Award, Outstanding ESG Governance Performance Award, and ESG Commendation Award, recognising our measurable achievements in community engagement, strong governance, and our green practices across the hospital that reduce our environmental footprint. We will continue to embed ESG principles across all operations and drive sustainable, long-term value for the community.

News Update



New Feature in Doctor's Portal App

In our commitment to environmental protection, we launched the electronic doctor fee statement in mid-August for doctors with codes beginning with A, D, K, R, S, W, and Y through our Doctor's Portal App. We are pleased to inform you that this feature will be extended to doctors with RMO, C, T, and V codes by the end of this year.

To accommodate those who may have difficulty accessing the Doctor's Portal App, we will also provide an electronic version that can be received via email.

If you have any inquiries or feedback regarding the Doctor's Portal App, please feel free to call ITS Department at 9137 7115 or email to it@union.org.

Download App

Google

iOS

New Clinical Sessions

Specialty Clinic	
Booking & Enquiry: 2608 3222	Time Schedule
Obstetrics & Gynaecology **Dr Mak Ho Leung, Jimmy**	Mon 15:00 – 18:00 Thu 15:00 – 18:00 Sat 16:00 – 18:00

Specialty Clinic	
Booking & Enquiry: 2608 3366	Time Schedule
Genetics and Genomics (Paediatrics) **Dr Lo Fai Man, Ivan**	Mon 09:30 – 13:00

Specialty Clinic	
Booking & Enquiry: 2608 3368	Time Schedule
Ophthalmology **Dr Chan Chi Wang, Jeffrey**	Mon 09:15 – 14:00* Tue 15:00 – 18:00 Wed 15:00 – 18:00 Thu 10:00 – 14:00 Fri 16:00 – 18:00 Sat 13:00 – 16:00
Ophthalmology **Dr Chan Yee Yan, Yvonne**	Mon 09:30 – 12:00* Tue 09:30 – 12:00 Wed 11:00 – 13:00 Fri 10:00 – 13:00
Ophthalmology **Dr Far Ying, Nikki**	Mon 14:30 – 17:00 Wed 09:00 – 11:00 Thu 14:30 – 17:00
* Will be on duty on alternative weeks	

Specialty Clinic	
Booking & Enquiry: 2608 3366	Time Schedule
Speech Therapy **Ms Kwong Ka Yi**	Thu 10:00 – 13:00

Union Hospital Polyclinic (Tsim Sha Tsui)	
Booking & Enquiry: 2375 3323	Time Schedule
Ophthalmology **Dr Chan Yee Yan, Yvonne**	Mon 15:00 – 18:00* Wed 15:30 – 17:30 Thu 10:00 – 13:00
* Will be on duty on alternative weeks	

Union Hospital Polyclinic (Ma On Shan)	
Booking & Enquiry: 2608 3377	Time Schedule
Ophthalmology **Dr Chan Yee Yan, Yvonne**	Tue 14:00 – 18:00 Thu 15:00 – 18:00 Fri 15:00 – 18:00 Sat 09:30 – 12:30 14:00 – 17:00
Ophthalmology **Dr Yeung Yat Shan**	Thu 14:00 – 15:00
Psychiatry **Dr Leung Chi Ming**	Wed 15:30 – 18:00 Fri 16:00 – 18:00

Union Hospital Polyclinic (Tseung Kwan O)	
Booking & Enquiry: 2721 0100	Time Schedule
Orthopaedics and Traumatology **Dr Lam Kin Wai**	Tue 16:30 – 18:00 Thu 16:00 – 18:30

Regular Meetings

Meeting :	X-Ray Meeting
Date : Time :	10 December 2025 (Wednesday) 8:30am – 9:30am
Co-ordinator:	**Dr CHAN Chi Sang, James** **Head, Department of Medical Imaging, Union Hospital**
Venue:	Training Room, 8/F MIC, Hospital Building, Union Hospital
Booking & Enquiry:	2608 3160 (Quality Assurance and Training Department)

CME Programme

Real World Application of Genetics and Genomics in Today's Healthcare

Date : 5 December 2025 (Friday)

Time : 2:00pm-3:00pm
(Lunch Buffet will be served at 1:15pm)

Venue : 2/F Seminar Room, Union Hospital

Speaker : **Dr Lo Fai Man, Ivan**

Honorary Clinical Associate Professor, Department of Paediatrics, CUHK

Chairperson : **Dr Fung Cheuk Man, Ronald**
Deputy Head, Department of Paediatrics, Union Hospital

On-site Registration
2608 3180

Online Registration (Zoom)
cme@union.org

New Clinical Members

Please extend a warm welcome to the following health professionals for joining our clinical team!

Dr Shum Chui Yu
Consultant in Clinical Oncology

Dr Chan Yee Yan
Specialist in Ophthalmology

Dr Lo Fai Man
Consultant in Genetics and Genomics (Paediatrics)

Dr Lip Tin Lam
Specialist in Cardiology

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